		FOR OHF USE					

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2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0004630

Facility Name: Christian Nursing Home

Address: 1507 - 7th Street (Number) Lincoln (City) 62656 (Zip Code)

County: Logan

Telephone Number: 217-732-2189 **Fax #** 217-732-8686

IDPA ID Number: 37-0841562004

Date of Initial License for Current Owners: 09/01/1965

Type of Ownership:

x	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
x	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code	501c3		Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: William O. Buskirk **Telephone Number:** 217-525-1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 7/01/03 to 6/30/03 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) Mark Havrilka
(Title) Chief Financial Officer

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title) William O. Buskirk, CPA
(Firm Name & Address) Eck, Schafer & Punke LLP, 600 East Adams Springfield, IL 62701-1624
(Telephone) 217-525-1111 Fax # 217-525-1120

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Christian Nursing Home # 0004630 Report Period Beginning: 7/01/03 Ending: 6/30/03

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	109	Skilled (SNF)	110	40,150	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	109	TOTALS	110	40,150	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	9,983	8,597	2,306	20,886	8
9	SNF/PED					9
10	ICF	3,838	4,778		8,616	10
11	ICF/DD					11
12	SC	3,918	5,093		9,011	12
13	DD 16 OR LESS					13
14	TOTALS	17,739	18,468	2,306	38,513	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.92%

D. How many bed-hold days during this year were paid by Public Aid? 138 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [x] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [x] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 09/01/1965

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date NO [x]

K. Was the facility certified for Medicare during the reporting year?
YES [x] NO [ ] If YES, enter number of beds certified 61 and days of care provided 2,306

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

Tax Year: 06/30/2003 Fiscal Year: 06/30/2003

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Christian Nursing Home # 0004630 Report Period Beginning: 7/01/03 Ending: 6/30/03

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	174,513	31,675	9,889	216,077		216,077		216,077			1
2	Food Purchase		219,135		219,135		219,135	74	219,209			2
3	Housekeeping	158,163	25,998		184,161		184,161		184,161			3
4	Laundry											4
5	Heat and Other Utilities			120,784	120,784		120,784	5,377	126,161			5
6	Maintenance	73,394	1,224	61,517	136,135		136,135	8,982	145,117			6
7	Other (specify):*											7
8	**TOTAL General Services**	406,070	278,032	192,190	876,292		876,292	14,433	890,725			8
	B. Health Care and Programs											
9	Medical Director			400	400		400		400			9
10	Nursing and Medical Records	1,705,883	147,766	6,817	1,860,466		1,860,466		1,860,466			10
10a	Therapy			454,474	454,474		454,474		454,474			10a
11	Activities	23,026			23,026		23,026	1,210	24,236			11
12	Social Services	100,501	1,019	7,641	109,161		109,161		109,161			12
13	Nurse Aide Training											13
14	Program Transportation		839		839		839	(2,201)	(1,362)			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,829,410	149,624	469,332	2,448,366		2,448,366	(991)	2,447,375			16
	C. General Administration											
17	Administrative	80,663	875	210,600	292,138		292,138	(162,233)	129,905			17
18	Directors Fees											18
19	Professional Services			1,841	1,841		1,841	7,681	9,522			19
20	Dues, Fees, Subscriptions & Promotions			22,489	22,489		22,489	(5,885)	16,604			20
21	Clerical & General Office Expenses	53,046	5,406	38,478	96,930		96,930	56,406	153,336			21
22	Employee Benefits & Payroll Taxes			402,635	402,635		402,635	21,349	423,984			22
23	Inservice Training & Education											23
24	Travel and Seminar			10,505	10,505		10,505	7,277	17,782			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			77,479	77,479		77,479	3,207	80,686			26
27	Other (specify):*											27
28	**TOTAL General Administration**	133,709	6,281	764,027	904,017		904,017	(72,198)	831,819			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,369,189	433,937	1,425,549	4,228,675		4,228,675	(58,756)	4,169,919			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Christian Nursing Home #0004630 Report Period Beginning: 7/01/03 Ending: 6/30/03

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			200,891	200,891		200,891	17,108	217,999			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			62,642	62,642		62,642	(32,388)	30,254			32
33	Real Estate Taxes			983	983		983		983			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			264,516	264,516		264,516	(15,280)	249,236			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			16,757	16,757		16,757		16,757			39
40	Barber and Beauty Shops			17,106	17,106		17,106		17,106			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			60,147	60,147		60,147		60,147			42
43	Other (specify):* **Apt/Congregate**			485,936	485,936		485,936	(2,877)	483,059			43
44	**TOTAL Special Cost Centers**			579,946	579,946		579,946	(2,877)	577,069			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,369,189	433,937	2,270,011	5,073,137		5,073,137	(76,913)	4,996,224			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Christian Nursing Home # 0004630 Report Period Beginning: 7/01/03 Ending: 6/30/03

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(36)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	3,764	30		9
10	Interest and Other Investment Income	(130,346)	32		10
11	Discounts, Allowances, Rebates & Refunds	(1,922)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest	(2,877)	43		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(2,201)	14		16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(16,246)	21		24
25	Fund Raising, Advertising and Promotional	(4,740)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Attached	95,790			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (58,814)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(18,099)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (18,099)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (76,913)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Christian Nursing Home

ID# **0004630**

Report Period Beginning: **7/01/03**

Ending: **6/30/03**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Vending	$ 110	2	1
2	Activity	1,210	11	2
3	Miscellaneous Revenue	(2,343)	17	3
4	Marketing	(1,145)	20	4
5	Exempt Interest Income - Endowment	97,958	32	5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	95,790		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Christian Nursing Home # 0004630 **Report Period Beginning:** 7/01/03 **Ending:** 6/30/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	74	0	0	0	0	0	0	0	0	0	0	74	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	5,377	0	0	0	0	0	0	0	0	0	5,377	5
6	Maintenance	0	8,982	0	0	0	0	0	0	0	0	0	8,982	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	74	14,359	0	0	0	0	0	0	0	0	0	14,433	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	1,210	0	0	0	0	0	0	0	0	0	0	1,210	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	(2,201)	0	0	0	0	0	0	0	0	0	0	(2,201)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(991)	0	0	0	0	0	0	0	0	0	0	(991)	16
	C. General Administration													
17	Administrative	(2,343)	(159,890)	0	0	0	0	0	0	0	0	0	(162,233)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	7,681	0	0	0	0	0	0	0	0	0	7,681	19
20	Fees, Subscriptions & Promotions	(5,885)	0	0	0	0	0	0	0	0	0	0	(5,885)	20
21	Clerical & General Office Expenses	(18,168)	74,574	0	0	0	0	0	0	0	0	0	56,406	21
22	Employee Benefits & Payroll Taxes	0	21,349	0	0	0	0	0	0	0	0	0	21,349	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	7,277	0	0	0	0	0	0	0	0	0	7,277	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	3,207	0	0	0	0	0	0	0	0	0	3,207	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(26,396)	(45,802)	0	0	0	0	0	0	0	0	0	(72,198)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(27,313)	(31,443)	0	0	0	0	0	0	0	0	0	(58,756)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number Christian Nursing Home **#** 0004630 **Report Period Beginning:** 7/01/03 **Ending:** 6/30/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	3,764	13,344	0	0	0	0	0	0	0	0	0	17,108	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(32,388)	0	0	0	0	0	0	0	0	0	0	(32,388)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(28,624)	13,344	0	0	0	0	0	0	0	0	0	(15,280)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(2,877)	0	0	0	0	0	0	0	0	0	0	(2,877)	43
44	**TOTAL Special Cost Centers**	(2,877)	0	0	0	0	0	0	0	0	0	0	(2,877)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(58,814)	(18,099)	0	0	0	0	0	0	0	0	0	(76,913)	45

Facility Name & ID Number Christian Nursing Home # 0004630 Report Period Beginning: 7/01/03 Ending: 6/30/03

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See attached schedule						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	5	Utilities	$	Christian Homes Inc	100.00%	$ 5,377	$ 5,377	1
2	V	6	Maintenance				8,982	8,982	2
3	V	17	Administrative	210,600			50,710	(159,890)	3
4	V	18	Directors						4
5	V	19	Professional Service				7,681	7,681	5
6	V	20	Fees, Subscriptions						6
7	V	21	Clerical				74,574	74,574	7
8	V	22	Employee Benefits				21,349	21,349	8
9	V	23	Inservice Training						9
10	V	24	Travel & Seminar				7,277	7,277	10
11	V	26	Insurance				3,207	3,207	11
12	V	30	Depreciation				13,344	13,344	12
13	V								13
14	Total			$ 210,600			$ 192,501	$ * (18,099)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Christian Nursing Home # 0004630 Report Period Beginning: 7/01/03 Ending: 6/30/03

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	This workpaper is not applicable.								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Christian Nursing Home # 0004630 Report Period Beginning: 7/01/03 Ending: 6/30/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1		This workpaper is not applicable.				$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Christian Nursing Home # 0004630 Report Period Beginning: 7/01/03 Ending: 6/30/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	1993-A GR Bonds - 90%	x		Debt Restructure		01/01/93	$ 450,000	$ 366,638	01/01/18	0.0650	$ 25,892	1
2	2001-Y GR Bonds	x						525,000		0.0700	36,750	2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 450,000	$ 891,638			$ 62,642	9
	B. Non-Facility Related*											
10	1993-A GR Bonds - 10%			Debt Restructure		01/01/93	50,000	40,737	01/01/18	0.0650	2,877	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$ 50,000	$ 40,737			$ 2,877	14
15	TOTALS (line 9+line14)						$ 500,000	$ 932,375			$ 65,519	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ Line # _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Christian Nursing Home # 0004630 Report Period Beginning: 7/01/03 Ending: 6/30/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2002 report.	*Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ N/A	2
3. Under or (over) accrual (line 2 minus line 1).		$ #VALUE!	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ #VALUE!	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1998		8
1999		9
2000		10
2001		11
2002		12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2002	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Christian Nursing Home COUNTY Logan

FACILITY IDPH LICENSE NUMBER 0004630

CONTACT PERSON REGARDING THIS REPORT Brenda Lavin

TELEPHONE 217-732-9651 FAX #: 217-732-8686

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	12-036-031-00	12-704 S36 T20 R3	$ 721.88	$
2.	12-623-005-00	12-3054	$ 245.42	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 967.30	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES x NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

Facility Name & ID Number Christian Nursing Home # 0004630 Report Period Beginning: 7/01/03 Ending: 6/30/03

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 40,088 B. General Construction Type: Exterior Masonry Frame Steel Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [x] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [ ] (a) Own the Equipment [x] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

Apartments
Congregate Building
Duplexes

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred: None
2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization:
4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	43,560	Various	$ 83,965	1
2	Home Office Allocation			7,217	2
3	TOTALS	43,560		$ 91,182	3

Facility Name & ID Number Christian Nursing Home # 0004630 Report Period Beginning: 7/01/03 Ending: 6/30/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	48		1965	1965	$ 272,125	$ 6,411	40	$ 6,803	$ 392	$ 225,416	4
5	26		1969	1969	282,500	6,637	36	7,847	1,210	237,335	5
6	26		1972	1972	318,878	7,501	33	9,663	2,162	258,733	6
7	9			2000	1,279,292	31,982	40	31,982		87,951	7
8	Home Office Allocations				52,050	1,496		1,496		26,881	8
	Improvement Type**										
9	Building Improvement			1965	48,022		20				9
10	Building Improvement			1969	49,853		20				10
11	Building Improvement			1972	56,049		20				11
12	Insulation/Fire Doors			1979	11,989	266	45	266		6,406	12
13	Windows & Improvements			1980	36,891	1,054	35	1,054		25,296	13
14	Water Sentry			1980	604		5			604	14
15	Furnace			1981	2,005		15			2,005	15
16	Laundry Room			1981	4,253	125	34	125		2,813	16
17	Folding Door			1982	429	7	20	7		429	17
18	Cooling Unit			1982	7,070		15			7,070	18
19	Garage			1982	2,875		15			2,875	19
20	Roofing			1982	9,373		5			9,373	20
21	Heating Control System			1983	8,969		15			8,969	21
22	Fan			1983	243		10			243	22
23	Roof Repairs			1983	34,602		15			34,602	23
24	Office Lights			1984	487		10			487	24
25	Water Heaters			1984	2,661		15			2,661	25
26	A/C Units			1984	12,415		8			12,415	26
27	Kitchen Doors			1984	2,008	100	20	100		1,908	27
28	Compartment			1984	264		10			264	28
29	Wallpapering			1985	5,014		5			5,014	29
30	Roof Repairs			1985	50,063		5			50,063	30
31	Glazing Panels			1985	17,986	719	25	719		12,942	31
32	Windows			1985	7,800	223	35	223		4,014	32
33	Condensing Unit			1985	1,735		10			1,735	33
34	Cabinet & Sink Tops			1986	2,302		15			2,302	34
35	Building Improvement			1986	8,250	330	25	330		5,665	35
36	Gravel Roof			1986	2,986		15			2,986	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Christian Nursing Home # 0004630 Report Period Beginning: 7/01/03 Ending: 6/30/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Access Panel	1986	$ 111	$ 6	20	$ 6	$	$ 102	37
38	A/C Unit	1986	10,500	525	20	525		8,881	38
39	Wall Cabinet	1986	191		10			191	39
40	Laundry Floor Cover	1986	1,157		5			1,157	40
41	Drapes	1986	2,282		5			2,282	41
42	Laundry Room	1986	26,110	1,306	20	1,306		21,661	42
43	Laundry Floor	1987	3,196		5			3,196	43
44	Sprinkler System	1987	120	6	20	6		98	44
45	Wall Bumper	1987	211	11	20	11		179	45
46	Fire Alarm	1987	499	25	20	25		407	46
47	Life Safety Work	1987	9,104	455	20	455		7,394	47
48	Life Safety	1987	266	27	10	27		262	48
49	Shuttering	1987	893	45	20	45		724	49
50	Wallcovering	1987	285		5			285	50
51	Carpeting	1987	1,817		5			1,817	51
52	Beauty Shop Floor	1987	618		5			618	52
53	Remodeling	1987	200	20	10	20		200	53
54	Life Safety	1987	1,284		10			1,284	54
55	Chaplains Office	1987	667		5			667	55
56	Life Safety	1987	1,875	175	10	175		1,875	56
57	Cabinets Beauty Shop	1987	558	9	15	9		558	57
58	Glass Windows	1987	2,396	120	20	120		1,890	58
59	Lights	1987	364		10			364	59
60	Metal Door	1987	440	22	20	22		343	60
61	Water Heater	1987	4,701		10			4,701	61
62	3-Ply Pitch Roof	1988	6,150	410	15	410		6,048	62
63	New A/C Work	1989	6,066	303	20	303		4,394	63
64	A/C System	1989	42,748	2,137	20	2,137		30,808	64
65	Ceiling Tiles	1989	351		5			351	65
66	Fire Dampers	1989	1,881		10			1,881	66
67	Replace Door	1989	657	33	20	33		459	67
68	Condensing Unit	1989	700		5			700	68
69	Sprinkler System	1989	4,106	205	20	205		2,836	69
70	TOTAL (lines 4 thru 69)		$ 2,724,547	$ 62,691		$ 66,455	$ 3,764	$ 1,148,070	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Christian Nursing Home # 0004630 Report Period Beginning: 7/01/03 Ending: 6/30/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 2,724,547	$ 62,691		$ 66,455	$ 3,764	$ 1,148,070	1
2	Life Safety	1989	458	2	10	2		458	2
3	Stain Glass Windows	1989	475		10			475	3
4	Remodel Dining Room	1990	2,970		10			2,970	4
5	Circulating Pump	1990	705	47	15	47		619	5
6	Replace /Install Window	1990	710	20	35	20		262	6
7	Doors	1990	508	25	20	25		323	7
8	Roofing A/C	1990	1,732	115	15	115		1,485	8
9	Water Heater	1990	2,275	152	15	152		1,951	9
10	A/C Unit	1990	10,186		10			10,186	10
11	Wallpaper	1991	2,544		5			2,544	11
12	Modular Nurse Station	1991	9,321		10			9,321	12
13	Roll Cover Base	1991	599		10			599	13
14	Wallpaper	1991	1,807		5			1,807	14
15	Wallcoverings	1991	5,774		5			5,774	15
16	A/C Compressor	1991	7,007		10			7,007	16
17	Cafeteria Window	1991	711	20	35	20		242	17
18	Base Cabinet	1991	666	44	15	44		517	18
19	Roof Work	1991	2,900	193	15	193		2,252	19
20	Water Heater	1991	1,288	86	15	86		996	20
21	Remodeling 32 Rooms	1992	25,027	1,251	20	1,251		14,282	21
22	Life Safety	1992	814	81	20	81		785	22
23	Doors (5)	1992	2,550	128	20	128		1,440	23
24	Smoke Heads Fire Relay	1992	1,235	62	20	62		698	24
25	Cove Base (120')	1992	591		10			591	25
26	Install Sprinklers	1992	1,382	69	20	69		770	26
27	Life Safety	1992	973	97	20	97		923	27
28	Furnaces	1992	13,165	658	20	658		7,074	28
29	Wall Paper	1992	3,376		5			3,376	29
30	Carpeting	1993	5,313		5			5,313	30
31	Lighting	1993	954	67	10	67		954	31
32	Air Conditioner	1993	4,475	406	10	406		4,475	32
33	Reroof	1993	8,477	385	22	385		3,882	33
34	TOTAL (lines 1 thru 33)		$ 2,845,515	$ 66,599		$ 70,363	$ 3,764	$ 1,242,421	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Christian Nursing Home # 0004630 Report Period Beginning: 7/01/03 Ending: 6/30/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 2,845,515	$ 66,599		$ 70,363	$ 3,764	$ 1,242,421	1
2	SW Roof	1993	900	41	22	41		403	2
3	Furnaces	1993	4,570	229	20	229		2,214	3
4	Lighting Life Safety	1994	973	97	10	97		897	4
5	Panels/Base Dayroom	1994	860		5			860	5
6	Drive Up/Curb Canopy	1994	7,108	711	10	711		6,517	6
7	Door Alarms	1994	851		5			851	7
8	Doors	1994	1,319	132	10	132		1,177	8
9	Front Entrance	1995	11,006	1,101	10	1,101		8,716	9
10	Roof	1995	6,300		5			6,300	10
11	Roof	1995	15,582	1,558	10	1,558		12,075	11
12	Front Entrance	1996	7,125	713	10	713		5,288	12
13	Roof Work	1996	3,400		5			3,400	13
14	Cnds. Unit-100	1996	2,742	274	10	274		1,941	14
15	Roof Work	1996	536		5			536	15
16	Roof Work Ewing	1996	3,062		5			3,062	16
17	Roof Repairs	1996	1,279		5			1,279	17
18	Lights & Dampers	1997	17,712	1,771	10	1,771		11,364	18
19	Courtyard Door	1997	972	97	10	97		574	19
20	Office Roof Work	1997	2,275	76	5	76		2,275	20
21	Roof Work 100 Wing	1997	13,120	1,312	10	1,312		7,653	21
22	Floor Covering	1997	2,091	140	5	140		2,091	22
23	Roof Work N&S Wing	1998	12,500	1,250	10	1,250		6,458	23
24	South Wing Roof Work	1998	14,800	1,480	10	1,480		7,449	24
25	A/C in Lobby	1998	1,226	123	10	123		625	25
26	Compressor - Laundry	1998	1,914		3			1,914	26
27	Roof Work	1999	1,920	384	5	384		1,920	27
28	Roof Work - Valley Area	1999	5,073	1,015	5	1,015		4,990	28
29	Carpeting 300 Wing	1999	11,167	2,233	5	2,233		10,607	29
30	A/C Unit 300 Wing	1999	4,284	428	10	428		2,033	30
31	Roof Work Dining Area	1999	6,590	1,318	5	1,318		6,261	31
32	Wallpaper 300 Wing	1999	12,512	2,502	5	2,502		11,467	32
33	Carpet Conference	1999	978	196	5	196		915	33
34	TOTAL (lines 1 thru 33)		$ 3,022,262	$ 85,780		$ 89,544	$ 3,764	$ 1,376,533	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Christian Nursing Home # 0004630 Report Period Beginning: 7/01/03 Ending: 6/30/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 3,022,262	$ 85,780		$ 89,544	$ 3,764	$ 1,376,533	1
2	Carpet Lobby	1999	5,021	1,004	5	1,004		4,685	2
3	Carpeting	1999	3,473	695	5	695		3,128	3
4	Office A/C Unit	1999	2,715	272	10	272		1,201	4
5	Carpeting	1999	1,743	349	5	349		1,512	5
6	Roof Work	1999	3,665	733	5	733		3,115	6
7	Remodel Beauty Shop	1999	1,339	268	5	268		1,117	7
8	Roof work	2000	5,536	1,107	5	1,107		4,336	8
9	Opto 22 energy management	2000	14,795	986	15	986		3,698	9
10	AD Smith water heater	2000	3,195	320	10	320		1,200	10
11	Water heater	2000	5,590	559	10	559		2,003	11
12	Handwash station	2000	1,140	76	15	76		266	12
13	Kitchen expansion	2000	790,605	19,765	40	19,765		65,883	13
14	Wallcover Staff DR	2000	933	187	5	187		623	14
15	Storage cabs	2000	676	45	15	45		150	15
16	Condensing unit	2000	2,530	169	15	169		535	16
17	Compressor laundry	2000	1,524	127	15	127		402	17
18	Heaters in Dayroom	2000	1,029	69	15	69		184	18
19	Wallpaper Secretary Office	2001	2,943	589	5	589		1,423	19
20	Alzheimbers Addition	2000	90,006	2,250	40	2,250		6,188	20
21	NURSE CALL SYSTEM	2001	26,200	2,620	10	2,620		6,332	21
22	80 LIGHT FIXTURES INSTALLED	2001	5,000	500	10	500		1,208	22
23	12 SMOKE DETECTORS	2001	1,504	150	10	150		350	23
24	5 TON CONDENSING UNIT (100 WING)	2001	1,599	160	10	160		333	24
25									25
26	3 Swinging Fire Doors W/ Frames	2001	700	70	10	70		140	26
27									27
28	Sprinkler System(Kitchen/Dining Rm Area)	2001	565	57	10	57		114	28
29	Compressors Etc, 300 Wing	2001	1,732	577	3	577		1,154	29
30	3 Swinging Fire Doors W/ Frames	2001	12,304	1,230	10	1,230		2,153	30
31	Main Breaker - NH	2001	4,718	472	10	472		787	31
32	Vinyl For Various Ares	2001	8,528	1,706	5	1,706		2,701	32
33	Carpeting - Activity Room	2001	15,290	3,058	5	3,058		4,842	33
34	TOTAL (lines 1 thru 33)		$ 4,038,860	$ 125,950		$ 129,714	$ 3,764	$ 1,498,296	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Christian Nursing Home # 0004630 Report Period Beginning: 7/01/03 Ending: 6/30/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 4,038,860	$ 125,950		$ 129,714	$ 3,764	$ 1,498,296	1
2	Floor Coverings - 100/200 Wings	2002	28,850	5,770	5	5,770		6,732	2
3	Roof Repairs	2002	2,211	221	10	221		276	3
4	Replace Roof-Valley Area Main Bldg.	2002	5,100	510	10	510		553	4
5	(2) Hot water holding tanks	11/18/2002	9,434	419	15	419		419	5
6	Roof-Valley Replacement - 100 Hall	4/29/2003	5,100	128	10	128		128	6
7	Carpet/Wallpaper - Administrators Office	5/28/2003	2,555	85	5	85		85	7
8	Roof Repairs - 200 Hall	6/9/2003	4,600	38	10	38		38	8
9	10 x12 Storage shed	6/10/1999	1,578	158	10	158		645	9
10	Fully depreciated land improvements	6/30/1975	104,624		20			104,624	10
11	Landscaping and plants	5/23/1989	686	34	20	34		482	11
12	Survey and land clearing	5/7/1992	3,350	168	20	168		1,868	12
13	Fence, garbage area	9/30/1992	542	11	10	11		542	13
14	Landscaping entrance	5/4/1995	1,273	127	10	127		1,037	14
15	Landscaping, patio, water, lights	8/21/2000	30,266	3,026	10	3,026		8,661	15
16	Shuffleboard court	6/1/2003	785	13	5	13		13	16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,239,814	$ 136,658		$ 140,422	$ 3,764	$ 1,624,399	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Christian Nursing Home # 0004630 Report Period Beginning: 7/01/03 Ending: 6/30/03

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 631,751	$ 63,809	$ 63,809	$	Various	$ 300,623	71
72	Current Year Purchases	24,589	1,920	1,920		Various	1,920	72
73	Fully Depreciated Assets	192,036				Various	192,036	73
74	Home Office Allocation	90,333	9,565	9,565			50,012	74
75	TOTALS	$ 938,709	$ 75,294	$ 75,294	$		$ 544,591	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Transportation	1992 Bus	1992	$ 38,828	$	$	$	8	$ 38,828	76
77	Patient Transportation	1984 Mercury Gran Marquis	1984	2,291				3	2,291	77
78	Patient Transportation	1985 Chevy Van	1998	4,300				3	4,300	78
79	Home Office Allocation			10,408	2,283	2,283			4,776	79
80	TOTALS			$ 55,827	$ 2,283	$ 2,283	$		$ 50,195	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 5,325,532	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 214,235	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 217,999	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 3,764	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,219,185	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Apartment	$ 440,815	$ 15,379	$ 312,935	86
87	Congregate	2,074,965	59,861	1,004,455	87
88	Land	230,405			88
89	Duplex	1,743,868	55,358	781,819	89
90					90
91	TOTALS	$ 4,490,053	$ 130,598	$ 2,099,209	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: This workpaper is not applicable.

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2004	$
13.	/2005	$
14.	/2006	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Christian Nursing Home # 0004630 Report Period Beginning: 7/01/03 Ending: 6/30/03

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [x] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist	This	hrs							2
3	Licensed Recreational Therapist	workpaper	hrs							3
4	Licensed Physical Therapist	is not	hrs							4
5	Physician Care	applicable.	visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Christian Nursing Home # 0004630 Report Period Beginning: 7/01/03 Ending: 6/30/03

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 6/30/03 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 527,332	$	1
2	Cash-Patient Deposits	3,171		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 58,706)	560,822		3
4	Supply Inventory (priced at FIFO)	15,409		4
5	Short-Term Investments	478,661		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Accrued Interest Receivable	18,832		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,604,227	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	314,369		13
14	Buildings, at Historical Cost	8,027,973		14
15	Leasehold Improvements, at Historical Cost	204,030		15
16	Equipment, at Historical Cost	1,109,191		16
17	Accumulated Depreciation (book methods)	(4,236,725)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	2,030,244		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 7,449,082	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 9,053,309	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 128,516	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	3,171		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	177,091		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	967		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 309,745	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	932,375		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Funds in Trust/Security Deposits	812,385		43
44	Deferred apartment income	697,434		44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 2,442,194	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,751,939	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 6,301,370	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 9,053,309	$	48

***(See instructions.)**

Facility Name & ID Number Christian Nursing Home # 0004630 Report Period Beginning: 7/01/03 Ending: 6/30/03

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 6,088,070	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 6,088,070	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,013,304	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 1,013,304	17
	B. Transfers (Itemize):		
18	**Transfer Out to Affiliate**	(800,004)	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ (800,004)	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 6,301,370	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Christian Nursing Home # 0004630 Report Period Beginning: 7/01/03 Ending: 6/30/03

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,149,071	1
2	Discounts and Allowances for all Levels	(898,415)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,250,656	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	685,733	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 685,733	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	1,857	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	18,159	13
14	Non-Patient Meals	36	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	970	16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	11,766	19
20	Radiology and X-Ray	9,263	20
21	Other Medical Services	2,945	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 44,996	23
	D. Non-Operating Revenue		
24	Contributions	287,410	24
25	Interest and Other Investment Income***	130,346	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 417,756	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Residential/Congregate	685,413	28
28a	Unrealized G(L) on Investments/Sale of Equipment	1,887	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 687,300	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,086,441	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	876,292	31
32	Health Care	2,448,366	32
33	General Administration	904,017	33
	B. Capital Expense		
34	Ownership	264,516	34
	C. Ancillary Expense		
35	Special Cost Centers	519,799	35
36	Provider Participation Fee	60,147	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,073,137	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,013,304	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,013,304	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Christian Nursing Home # 0004630 Report Period Beginning: 7/01/03 Ending: 6/30/03

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,700	2,100	$ 54,135	$ 25.78	1
2	Assistant Director of Nursing	1,608	1,971	31,286	15.87	2
3	Registered Nurses	4,745	5,798	182,560	31.49	3
4	Licensed Practical Nurses	30,662	31,809	562,427	17.68	4
5	Nurse Aides & Orderlies	74,396	78,360	832,598	10.63	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,343	3,551	42,877	12.07	8
9	Activity Director	1,388	1,406	13,816	9.83	9
10	Activity Assistants	909	920	9,210	10.01	10
11	Social Service Workers	10,610	10,744	100,501	9.35	11
12	Dietician					12
13	Food Service Supervisor	1,858	1,905	27,922	14.66	13
14	Head Cook					14
15	Cook Helpers/Assistants	17,075	17,498	146,591	8.38	15
16	Dishwashers					16
17	Maintenance Workers	5,452	5,503	73,394	13.34	17
18	Housekeepers	17,451	18,234	158,163	8.67	18
19	Laundry					19
20	Administrator	1,850	1,963	80,663	41.09	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,425	1,512	21,218	14.03	23
24	Clerical	2,748	2,912	31,828	10.93	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	177,220	186,186	$ 2,369,189 *	$ 12.72	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	219	$ 9,889	1.3	35
36	Medical Director	72	400	9.3	36
37	Medical Records Consultant	18	1,470	10.3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	120	1,100	10.3	39
40	Physical Therapy Consultant	3,740	247,134	10A.3	40
41	Occupational Therapy Consultant	2,319	155,502	10A.3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	654	51,838	10A.3	43
44	Activity Consultant				44
45	Social Service Consultant	64	3,741	12.3	45
46	Other(specify) UR Committee Fees		1,000	10.3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	7,206	$ 472,074		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Christian Nursing Home # 0004630 Report Period Beginning: 7/01/03 Ending: 6/30/03

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Dick Warren	Administrator	0	$ 80,663
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 80,663

B. Administrative - Other

Description	Amount
Management Fee	$ 210,600
TOTAL (agree to Schedule V, line 17, col. 3)	$ 210,600
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
FR & R Healthcare	Consulting	$ 450
Davis & Campbell	Legal	1,391
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 1,841

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 69,984
Unemployment Compensation Insurance	5,712
FICA Taxes	173,776
Employee Health Insurance	142,500
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Expense	7,758
Employee Physicals & Dental	2,529
Employee Uniforms	376
TOTAL (agree to Schedule V, line 22, col.8)	$ 423,984

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	5,055
Health Care Worker Background Check	
(Indicate # of checks performed)	
Support & Online Fee	3,936
Life Services Network	6,667
Annual & remote line fees	400
Miscellaneous dues & fees	546
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 16,604

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	467
Seminar Expense	9,971
Miscellaneous	67
Home Office Allocations	7,277
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 17,782

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Christian Nursing Home # 0004630 Report Period Beginning: 7/01/03 Ending: 6/30/03

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1	This workpaper is not applicable.		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Christian Nursing Home **#** 0004630 **Report Period Beginning:** 7/01/03 **Ending:** 6/30/03

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Life Services Network $6,667**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? _____

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **5-10**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **14,994** Line **3.10.2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? _____ YES **x** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **x** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

_____

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **60,147**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **36**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **0**
c. What percent of all travel expense relates to transportation of nurses and patients? **None**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **0**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Eck, Schafer & Punke LLP** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **No** If no, please explain. **It will be provided upon completion.**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.

Summary of Employee Expenses — kdb

The Christian Village — 6/30/2003 — 11/4/2005

Fica	Unemploy	Workers Compen	Health Ins	Benefit Percent	Employee Uniforms	Employee Expense	Employee Physical		
125,986.33	3,864.00	47,292.00	96,750.00						
12,708.61	540.00	6,612.00	10,500.00	5,916.06					
11,623.17	552.00	6,780.00	3,750.00	6,009.73					Check
5,053.01	180.00	2,196.00	12,000.00	3,106.94					430,090.90
8,698.68	372.00	4,608.00	12,375.00	3,595.97					
9,703.19	204.00	2,496.00	7,125.00		375.84	7,757.94	2,529.00		
				8,830.43					
173,772.99	5,712.00	69,984.00	142,500.00	27,459.13	375.84	7,757.94	2,529.00	430,090.90	
							benefits allocated to salary	-27,459.13	
								402,631.77	